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ABSTRACT

The article discusses approaches to the evaluation of severely and profoundly mentally retarded persons by recreational therapists. Considered are inventory assessments, medical profiles, interviews, and direct interactions with a client. The last phase of the evaluation process is summarizing and ordering the needs of the individual based on the data gathered. (CL)

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THE ASSESSMENT PROCESS IN RECREATION WITH SEVERELY AND PROFOUNDLY RETARDED POPULATIONS

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Teamwork and cooperation have provided this outstanding contribution to the Practical Pointers series and we are indebted for their joint efforts in this venture. Each brings personal training, background, and experience in addressing this important but too long neglected area. Mr. Crawford, a trained Rehabilitation Counselor, is currently a Recreation Therapist and Program Director at St. Joseph Hospital, Omaha, Nebraska. Dr. Griffin, Associate Professor, School of Health, Physical Education, and Recreation, University of Nebraska, Lincoln, has long been an advocate and professionally involved in both personnel preparation and service programs related to physical education and recreation opportunities designed for participants with various handicapping conditions. Dr. Mendell, a registered therapeutic recreation specialist, is Assistant Professor and Coordinator of the Recreation/Leisure Studies Program at the University of Nebraska at Omaha. To each of them, our thanks for presenting a difficult subject well and in doing a difficult job expertly.

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Severely and profoundly mentally retarded individuals have been too often isolated in marginal institutional programs. They often have had low priority in busy diagnostic clinics and have been of comparatively little interest to major helping professions. They present difficulties to burgeoning community facilities where private funding and government subsidies must ultimately be contingent upon results. They respond only very slowly and require training regimes which are often tedious.

A too common dichotomy within the mental retardation field is to view individuals as reclaimable or not, capable of achieving substantial and economic independence or nothing at all. However, success is a graded quality and a re'ative concept. Severely or profoundly retarded individuals who can achieve self-care to the limits of their biological capacities and appropriate to any given development stage must be judged successes. Physiologically uncomplicated moderately or mildly mentally retarded individuals might achieve somewhat more but be judged, comparatively, failures if such achievements fall short of potentials.

Many times before a therapeutic recreation specialist can begin to deal with what are traditionally considered recreative activities with severely and profoundly retarded individuals, he/she must attend to a host of other problems and behaviors to ready clients for activities. Because of complexities of problems presented by most severely and profoundly retarded individuals, a therapist must often be ready to engage in intensive assessment and long-range therapy planning efforts.

This Practical Pointer is to help illuminate some considerations and problems involved in such a treatment process and give recreation personnel some general guidelines for undertaking assessments and making treatment recommendations.

INVENTORY ASSESSMENT

In an inventory assessment with severely and profoundly retarded individuals, a therapist is not concerned with assessing developed recreational habits as there will be few. Rather concern lies in generating an accurate inventory of an individual's behavioral and interactional habit systems. This information may be drawn from a number of sources and concerns itself over a wide range of an individual's traits.

In an inventory assessment, review of records of a client is useful only in a general way. People are not static; an element unique to all individuals is that of change. What a particular client did one, five, or even twenty years ago may have no connection to his/her present day make-up. It may be useful in some cases, however, in identifying what may be some life long habit systems or interactional capacities or tolerances. Certainly a medical profile is useful in setting expectations and making appropriate demands within a therapeutic setting.

MEDICAL PROFILE

The following information should be drawn from a client's medical file, central record, or other appropriate client file sources.

Medical limitations are affected by allergies, medications, seizures, physical disabilities, restrictions, and influenced by information from intellectual and other types of assessments.

Observed behaviors include progress or incident reports from previous staff which may give good indications of strengths and weaknesses of a client. Included under this section are repetitive, disruptive, or abusive behaviors; reinforcers and/or programing successes; cyclical behaviors and significant objects or individuals to which a client responds positively.

INTERVIEWS

As a second step in over-all assessment, interviews of direct care personnel involved with a client on a continuing and/or daily basis are necessary. This assessment could include ward or unit personnel, parents, teachers, psychological staff, and others.

Questions posed to direct care staff or parents should not be phrased so as to require yes or no answers--Does John enjoy going to baseball games? Oftentimes direct care personnel and/or parents are eager to please professional staff and answer in ways they think a professional expects. They may color or distort reports so as to give favorable pictures of their child, client, living unit, or of themselves. Parents may have similar tendencies to offer only positive pictures and/or exaggerate capacities of their handicapped child. A therapist should make the interview low-keyed, drawing a staff member or parent

out slowly--tell me about John's day, his programs. How does he get along with peers? With you? What does he like? Not like? If responses are all favorable, and you have good reasons to feel that there is more to John than these positive reports, try a more direct approach--Mr. and Mrs. Smith, when are those times that you find John really trying? Mr. Staff Member, when is John really in the way or a cause for extra work?

In the case of working with direct care staff, more than one staff member should be interviewed. Those interviewed should also represent more than one shift of coverage as a client may react differently to different staff, and behavior patterns may be decidedly different at different times of the day. Try to determine what might be the best time of the day to work with a client.

DIRECT INTERACTION WITH A CLIENT

The last part of the general observations phase deals with direct interaction with a client. Several areas in this instructional/observational process will yield important information concerning make-up, rate, and direction of a therapeutic recreation program for a client. Among these areas are interactional capacity, tolerance to task, levels of social and physical prompts and hands-on manipulation, fine and large motor deficits or skills, general behavior and affective make-up, ability and/or frequency to initiate interaction, reactions to aggression, interactions, and/or stress, expressive and receptive language abilities, unusual problem solving behaviors, and relevant reinforcers.

Interactional capacity includes interactions with individuals, objects, and the environment. Despite intellectual or physical impairments, is the individual alert? Does he/she actively seek experiences, greet strangers or staff in some fashion? Seek out activity or objects? Explore new environments? Or is he/she passive? Does he/she merely wait for demands to be placed upon him/her? Does the client react defensively or aggressively to new situations? Do stress and/or performance factors require interactional capacities that threaten the client's sense of security and identity?

Tolerance to task deals with how an individual tolerates involved performance factors once engaged in a task. Are skills necessary to achieve a task within the individual's capacities? Does he/she tire quickly or lose interest in using these skills? How much prompting--verbal, physical, manual guidance, or combination of all--and on what level can each be used before tolerance is reached?

Levels of social and physical tolerance focus on situations, environments, performance factors and/or individuals that upset a client. Will the client allow close physical proximity or contact with strangers? With familiar people? Does he/she show an avoidance response if another individual sits or moves close? Places hands on him/her? Does he/she allow this passively? Does he/she resist this? Does the client show curiosity to your presence? What environments upset the individual? Do large groups require too much self-control or patience for this individual? Does he/she seek a corner or a certain amount of personal space? If denied this space does the client become upset?

Attention span deals with how long a client attends to a physical activity. Will he/she attend to verbal commands or cues? What techniques work in holding the individual's attention? What behaviors or activities hold his/her attention without prompting? Does the individual spend a majority of time in self-stimulatory types of behavior? How do staff and/or parents control or channel this behavior into daily living tasks?

Tolerance to physical prompts and hands on manipulation indicates there are certain client-trainer positions--trainer behind, in front of, beside client--which a client is wary or untrusting of in the use of physical prompts. Must the client have a full view of the trainer to allow physical prompting? Is the client uncomfortable with being touched? If such contact is aversive, you may have a tactile defensive individual who may require a tactile stimulatory or relaxation-inhibition perceptual motor training program. Does the client enjoy physical prompts or holding? Could this be used as a reinforcer during a training program?

Fine and large motor skills or deficits often show in balance and ambulation problems. Does he/she sit with legs flexed in a wide base of support? Walk with a shuffle gait? Have difficulties with stairs? Do fine-motor tasks such as puzzles and paper pencil activities give the individual great difficulty? Does the individual use a pincer grasp? A client who displays any or all of these difficulties should be referred to a sensory-motor or perceptual-motor specialist for diagnosis and specific remedial activities. Most occupational therapists, many physical therapists, and some therapeutic recreation specialists, psychologists, and educators have needed assessment and programing skills to determine such needs.

General behavior and affective make-up can be rated to obtain general indications of any special environments or circumstances which cause these ratings to change. How do these ratings change. In rating affect it is important to link ratings with specific examples of behavior. Several examples may help clarify this concept.

- Confused--attempted task incorrectly; required assistance to complete.
- Easily upset--resisted prompts with any motor response; refused to enter activity area.
- Hostile/aggressive--abused others; hit; kicked; bit; pinched; scratched; pulled hair; pushed; took objects or turns from others; threw objects; abused self, others.
- Anxious--inappropriate verbalizations and/or laughing; left task area; repetitive motor movements unrelated to task.
- Distracted--often oriented toward stimuli other than task materials; must be directed to task often.
- Elated--often smiled and/or laughed appropriately.

- Cooperative--attempted task upon first instructions; allowed physical prompts or manipulations; responded to simple commands; oriented to task materials and/or instructor; manipulated materials as instructed.

- Rapid learner--imitated task related behavior which had been modeled only once; retained skills demonstrated during previous sessions.

- Explored environment/self-initiator--without prompting walked around new environment; without prompting oriented toward new stimuli within the environment; attempted task prior to instructions; requested different/new activities and/or objects.

Ability and/or frequency initiates interactions with others deals with how a client relates to peers. In what fashion? Positive? Negative? Neutral? Does the client relate to staff? For what reasons and in what fashion?

Reactions to aggression, interactions from peers and/or stress addresses such areas as a client's immediate reaction to aggression from peers. Does he/she counter? Aggress? Flee? Freeze? Passively receive aggression? Are there any long-term effects? Is his/her emotional make-up affected on a long-term basis? For one hour? Two hours? Does he/she seek revenge? Does he/she agree on objects or staff or self? Do training demands (stresses) cause the same reactions as acts of aggression? How does the client react to positive peer instruction?

Expressive and receptive language abilities focus on cognitive processes of an individual. Are they sufficient to allow for knowledge of prepositions of position (on, under, by, besides, over)? Can objects (brush, spoon) that he/she uses or interacts with daily be identified? Can the individual follow simple instructional commands such as look at me, stand up, sit down? If not, what level of prompt is required to get desired behavior? Modeling? Physical cue? Physical assistance?

Unusual problem solving behaviors note unusual abilities and/or insights in any of the domains. If a peer is upset does the client display comforting behaviors? If a peer behaves inappropriately, will the client take action? Aggress? When presented a large motor problem such as carrying an object or negotiating an obstacle will the client try several methods to find a solution? Is the individual able to plan deviate acts (manipulate peers or staff to receive reinforcement or objects not allowed to him/her normally)?

Relevant reinforcers--social, physical, edible, and object reinforcement--successfully used with a client are listed. Are these across the board reinforcers or specific to particular environments or individuals? Are punishment or negative reinforcements the only effective means that staff/parents use with this client? What elements in the individual's environment could perhaps take on reinforcing properties if developed in training sessions?

A special note should be made on information relating to reinforcers. Many times individuals react differently in one-to-one training or small group sessions than in other environments. Thus, a therapist should not lock an individual into a rigid structure or program based on information gathered through the

assessment process. Rather, this information should be used in a general way to determine such things as priorities, possible teaching strategy-techniques, environments, training areas, and reinforcers. A therapist should remain open to altering the strategy to fit changes in an individual's behavior or emotional make-up. Passive individuals can become quite threatened and aggressive when given one-to-one attention in a therapy room; quite the opposite may occur with habitually aggressive clients--therapists need to be prepared for this.

SUMMARY

In the last phase of assessment a therapist summarizes and orders needs of an individual based upon information gathered. This is the most difficult aspect of assessment. The weakness here lies in subjectiveness inherent in interpreting assembled information. Even if a therapist is reasonably satisfied that information obtained is accurate, reliable, and generally reflective of an individual's skills, this still does not make the decision of where to begin in terms of remediation.

Since each individual taken into therapeutic recreation programs possesses different needs, it is difficult to generate accurate statements as to how to program. This must ultimately be decided by each individual therapist, given limitations of physical resources on hand, the individual client involved, and the therapist's own individual skills and knowedge. However, some general guidelines basic to human development may be helpful when making recommendations for treatment.

Certainly if an individual demonstrated perceptual or motoric problems on evaluation should be done in these areas. Until an individual is freed motorically and perceptually, proper intake, processing, and output of information will be hampered and distorted. Such basics as balance, proper posture, ambulation, and ability to motor plan are prerequisites for many aspects of an individual's life, particularly those pertaining to recreation.

Specific recreational/leisure skills can quite often be utilized to improve various other areas of deficit such as tolerance to task, hands on manipulation, and interactional capacities. Activities such as arts and crafts, fine motor skill development, large motor playground and swimming skills, and sessions including activities with low stress and performance factors like listening to musical programs are effective aids in developing a positive client-therapist relationship. These activities also provide variety in an individual's daily living situation. Quite often it is possible and at times desirable to work on several specific skills within one session. It is also quite possible to work in some of these areas even when perceptual and motoric programing is going on at the same time.

Readiness skills, cognitive skills, and affective domains are the most difficult to plan for, most difficult to maintain, and most difficult to generalize to other environments or skill areas outside the therapy room. These concerns include such skills as expressive language components--spoken or signed--concepts of size, shape, color or dimension, and appropriate expressions of courtesies and needs. Facilitation of appropriate and efficient use of specific leisure skills should generally be given priority over many of these other areas.

Following the assessment inventory, a therapist begins to detail necessary programing efforts and time line procedures to be followed prior to therapeutic intervention. This detail includes but need not be limited to the recreational programing hierarchy, staffing ratio, teaching strategy--behavioral or developmental--reinforcers and other components necessary to fulfill goals of the therapeutic recreation program.